58-17-69. "Creditable coverage" defined. For purposes of §§ 58-17-66 to 58-17-87, inclusive, the term, creditable coverage, means benefits or coverage provided under:

(1) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan or an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 as adopted by the director pursuant to chapter 1-26, to the extent that the plan provides directly or through insurance, reimbursement or otherwise to employees or their dependents medical care for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body and amounts paid for the transportation primarily for and essential to medical care;

(2) An individual health benefit plan, including coverage issued by any health maintenance organization or pre-paid hospital or medical services plan that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan as approved pursuant to chapter 1-26, but excluding limited benefit plans and dread disease plans;

(3) Medicare or medicaid;

(4) Chapter 55 of Title 10, United States Code;

(5) A medical care program of the Indian Health Service or of a tribal organization;

(6) A state health benefits risk pool;

(7) A health plan offered under Chapter 89 of Title 5, United States Code;

(8) A public health plan;

(9) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e));

(10) A church plan;

(11) A college plan;

(12) A short term or limited duration plan; or

(13) An individual health benefit plan, including coverage issued by any health maintenance organization or pre-paid hospital or medical services plan that provided benefits less than the benefits provided under the basic health benefit plan as approved pursuant to chapter 1-26, but excluding the following excepted benefits:

(a) Coverage only for accident including accidental death and dismemberment;

(b) Disability income insurance;

(c) Liability insurance including general liability insurance and automobile liability insurance;

(d) Coverage issued as a supplement to liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit only insurance including mortgage insurance;

(h) Coverage for on-site medical clinics; and

(i) Limited scope dental and long-term care insurance, if provided under a separate policy, certificate, or contract of insurance, or not otherwise an integral part of a plan.

Source: SL 1996, ch 286, § 4; SL 1997, ch 289, § 2; SL 1998, ch 289, § 1; SL 1999, ch 250, § 1; SL 2001, ch 275, § 1; SL 2004, ch 301, § 1.

58-17-84. Provisions of compliance for any individual health benefit plan. Any health benefit plan covering individuals shall comply with the following provisions:

(1) No health benefit plan may deny, exclude, or limit benefits for a covered individual for claims incurred more than twelve months following the effective date of the person's coverage due to a preexisting condition. No health benefit plan may define a preexisting condition more restrictively than:

(a) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve months immediately preceding the effective date of coverage;

(b) A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage; or

(c) A pregnancy existing on the effective date of coverage;

(2) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the aggregate period of time a person was previously covered by creditable coverage, excluding limited benefit plans and dread disease plans that provided benefits with respect to such services, if the

creditable coverage was continuous to a date not more than sixty-three days before the application for the new coverage. A period of time a person was previously covered may not be aggregated if there was a break in coverage of sixty-three days or more. The plan shall count a period of creditable coverage without regard to the specific benefits covered under the plan, unless the plan elects to credit it based on coverage of benefits within several classes or categories of benefits specified in rules adopted pursuant to chapter 1- 26, by the director;

(3) A health maintenance organization which does not utilize a preexisting waiting period may use an affiliation period in lieu of a preexisting waiting period. No affiliation period may exceed two months in length. No premium may be charged for any portion of the affiliation period. If the health maintenance organization utilizes neither a preexisting waiting period nor an affiliation period, the health maintenance organization may use other criteria designed to avoid adverse selection provided that those criteria are approved by the director;

(4) Genetic information may not be treated as a condition for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information; and

(5) A condition may not be defined or considered as preexisting if the condition arose after a person began creditable coverage and if there was not a break in coverage which exceeded sixty-three days.

For purposes of this section, the effective date of coverage is the first day the person became covered for either accidents or sicknesses.

Source: SL 1996, ch 286, § 19; SL 1997, ch 289, § 4; SL 2001, ch 275, § 2; SL 2003, ch 248, § 2.

58-17-85. Acceptance of applicant with prior health benefit plan--Residency requirement--Application deadline. If a person has an aggregate of at least twelve months of creditable coverage, is a resident of this state, and applies within sixty-three days of the date of losing prior

creditable coverage, the person is eligible for coverage as provided for in §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, if none of the following apply:

(1) The applicant is eligible for continuation of coverage under an employer plan;

(2) The person is eligible for an employer group plan, Part A or Part B of medicare, or medicaid;

(3) The person has other health insurance coverage;

(4) The person's most recent coverage was terminated because of the person's nonpayment of premium or fraud;

(5) The person loses coverage under a short term or limited duration plan; or

(6) The person's last coverage was creditable coverage as defined in subdivision 58-17- 69(13).

Any person who has exhausted continuation rights and who is eligible for conversion or other individual or association coverage has the option of obtaining coverage pursuant to this section or the conversion plan or other coverage. If a person chooses conversion coverage, other than pursuant to § 58-17-74, in lieu of coverage pursuant to this section and the person later exhausts the lifetime maximum of the conversion coverage, the person may obtain coverage pursuant to this section as long as the person continues to satisfy the criteria of this section. A person who is otherwise eligible for the issuance of coverage pursuant to this section may not be required to show proof that coverage was denied by another carrier.

For purposes of this section, reasonable evidence that the prospective enrollee is a resident of this state shall be required. Factors that may be considered include a driver's license, voter registration, and where the prospective enrollee resides.

Any person who was eligible for the risk pool and opted for coverage pursuant to § 58-17-74 may, at any time while covered under that policy or within sixty-three days of terminating that coverage, elect to enroll in the risk pool.

Source: SL 1996, ch 286, § 20; SL 1997, ch 289, § 5; SL 1998, ch 289, § 3; SL 1999, ch 250, § 2; SL 2001, ch 275, § 3; SL 2002, ch 235, § 1; SL 2003 (SS), ch 1, § 30; SL 2004, ch 301, § 2; SL 2005, ch 264, § 1; SL 2008, ch 263, § 2.

58-17-114. Definitions. Terms used in §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, mean:

(1) "Carrier," any person that provides health insurance in the state, including an insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement, a carrier providing excess or stop loss coverage to a self-funded employer, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. The term, carrier, includes any health benefit plan issued through an association or trust. The term, carrier, does not include excess or stop loss covering a risk of insurance as defined in §§ 58-9-5 to 58-9-33, inclusive, and does not include health insurance for coverages that are not health benefit plans issued by insurance companies, prepaid hospital or medical service plans, or health maintenance organizations;

(2) "Director," the director of the Division of Insurance;

(3) "Enrollee," any individual who is provided qualified comprehensive health coverage under the risk pool;

(4) "Health benefit plan," as defined in subdivision 58-17-66(9);

(5) "Health care facility," any health care facility licensed pursuant to chapter 34-12;

(6) "Health insurance," as defined in § 58-9-3;

(7) "Medicaid," the federal-state assistance program established under Title XIX of the Social Security Act;

(8) "Medicare," the federal government health insurance program established under Title XVIII of the Social Security Act;

(9) "Policy," any contract, policy, or plan of health insurance;

(10) "Policy year," any consecutive twelve-month period during which a policy provides or obligates the carrier to provide health insurance.

Source: SL 2003 (SS), ch 1, § 2.

58-17-115. Health insurance coverage risk pool established. There is established a risk pool to provide health insurance coverage, pursuant to the provisions of §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, to each eligible South Dakota resident who applies for coverage after July 31, 2003.

Source: SL 2003 (SS), ch 1, § 3.

58-17-116. Administration of risk pool--Appointment of board--Members--Board may contract for performance of functions. A seven-member board appointed by the Governor shall administer the risk pool. The board shall include representatives of the Governor's Office, Department of Social Services, Bureau of Personnel, Department of Health, and Division of Insurance and two other persons appointed by the Governor. The board may contract for the performance of any of its functions.

Source: SL 2003 (SS), ch 1, § 4.

58-17-117. Board to request bids for administrator of risk pool--Effective date of bid--Board may continue administration in lieu of satisfactory bid--Oversight by board. The board shall request bids for an administrator of the risk pool. Such contract with an administrator shall be designed to become effective no later than July 1, 2005. If the board determines that the bids are not consistent with the efficient operation of the risk pool, the board may continue to administer the risk pool and to contract for services. Regardless, the board shall perform all appropriate oversight functions.

Source: SL 2003 (SS), ch 1, § 5.

58-17-118. Advisory panel established--Members--Terms--Functions. There is established an advisory panel to the board consisting of two lay members, one of which shall be an employee, and at least one representative of each of the following: individual health insurance carriers, group health insurance carriers, health care providers, insurance producers, health care facilities, self-insurers, and employers as well as one state senator appointed by the president pro tempore of the Senate and one state representative appointed by the speaker of the House of Representatives. The Governor shall appoint the nonlegislative representatives of the advisory panel for a specific term not less than two years and not more than three years. The terms of service shall overlap. The advisory panel may make recommendations to the board regarding benefits and exclusions in the risk pool coverage, eligibility for the risk pool, assessments of carriers, and operation of the risk pool. The board shall consider any input from the advisory panel in making any decisions relative to rule-making, benefits, exclusions, eligibility, assessments, and risk pool operation, and shall sponsor and attend such meetings as may be necessary between the board and the advisory panel to provide the input as required by this section.

Source: SL 2003 (SS), ch 1, § 6.

58-17-119. Administrative functions of board--Annual report to Legislature--Contents.

The board shall perform its functions in such a manner as to assure the fair and reasonable administration of the risk pool and to provide for the sharing of risk pool losses, if any, on an equitable and proportionate basis among the carriers. In addition to other requirements, the board is responsible for all of the following:

(1) The handling and accounting of assets and moneys of the risk pool;

(2) Procedures for assessing the carriers in proportion to the number of persons they cover through primary, excess, and stop loss insurance in this state;

(3) Methods for ensuring that all risk pool enrollees are and continue to be eligible for the risk pool; and

(4) Additional provisions necessary or proper for the execution of the powers and duties of the risk pool.

The board shall file a report with the Legislature each year on or before January first, which shall include information regarding the operation of the risk pool, such as assessments, numbers of enrollees, claims, expenses, and premiums.

Source: SL 2003 (SS), ch 1, § 7.

58-17-120. South Dakota risk pool fund established--Purpose. There is hereby established a South Dakota risk pool fund within the Bureau of Personnel to receive premiums, assessments, federal funds, and any claims and make payments either directly or indirectly to health care providers and others to carry out the functions of the risk pool.

Source: SL 2003 (SS), ch 1, § 8.

58-17-121. Powers and authority of board--Immunity not waived. The board has the general powers and authority enumerated by §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, and, in addition to the responsibilities in § 58-17-119, may:

(1) Enter into any contract as necessary or proper to carry out §§ 58-17-68, 58-17-70, 58-17- 85, and 58-17-113 to 58-17-142, inclusive;

(2) Take any legal action necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers;

(3) Take any legal action necessary to avoid the payment of improper claims against the risk pool or the coverage provided by or through the risk pool;

(4) Use medical review to determine that care is clinically appropriate and cost effective for the risk pool;

(5) Establish appropriate rates, scales of rates, rate classifications, and rating adjustments, none of which may be unreasonable in relation to the coverage provided and the reasonable operational expenses of the risk pool;

(6) Issue risk pool plans on an indemnity, network, or provision of service basis and may design, utilize, contract, or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements in providing the coverage required by §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive;

(7) Create appropriate legal, actuarial, and other committees necessary to provide technical assistance in the operation of the risk pool, plan and other contract design, and any other functions within the authority of the risk pool;

(8) Provide, by including a provision in its plans, for subrogation rights by the risk

pool for situations in which the risk pool pays expenses on behalf of an individual who is injured or suffers a disease under circumstances creating a liability upon another person to pay damages to the extent of the expenses paid by the risk pool, but only to the extent the damages exceed the plan deductible and coinsurance amounts paid by the enrollee; and

(9) Allow an applicant who is not otherwise eligible for coverage pursuant to § 58-17-85 to enroll in the risk pool if all of the following are met:

(a) The applicant is covered by an individual health benefit plan that is no longer being marketed in this state and has a premium rate that exceeds two hundred percent of the applicable rate, based upon that person's rating characteristics, charged to risk pool enrollees;

(b) The risk pool's financial solvency would not be impaired by enrolling the applicants under this subdivision;

(c) Sufficient federal funding exists to cover expected losses for those enrolled pursuant to this subdivision; and

(d) The number of applicants enrolled into the risk pool pursuant to this subdivision in any given calendar year does not exceed three percent of the total number of covered persons in individual health benefit plans that are no longer being marketed in this state.

Nothing in §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, constitutes a waiver of immunity.

Source: SL 2003 (SS), ch 1, § 9; SL 2006, ch 255, § 1.

58-17-122. Third-party liability--Subrogation of third-party payment by risk pool--Waiver of subrogation rights. If a claim to the risk pool for which benefits are payable under the risk pool exists under circumstances creating in some other person a legal liability to pay damages in respect thereto, the enrollee may either make claim to the risk pool or proceed at law against such other person to recover damages or proceed against both the risk pool and such other person. However, if the injured enrollee recovers any like damages from such other person,

the recovered damages shall be an offset against any risk pool benefits which the enrollee would otherwise have been entitled to receive. If claims have been paid by the risk pool and the enrollee has recovered damages from another person, the risk pool may recover from the enrollee an amount equal to the amount of the claim paid to the enrollee by the other person, less the necessary and reasonable expense of collecting the same. However, the risk pool may waive its subrogation rights if it determines that the exercise of the rights would be impractical, uneconomical, or would create a hardship on the enrollee.

Source: SL 2003 (SS), ch 1, § 10.

58-17-123. Notification of coverage status to health care or pharmacy provider--Request for payment constitutes agreement--Reimbursement rates--Provider barred from billing enrollee for covered services. An enrollee shall notify any health care provider or any provider of pharmacy goods or services prior to receiving goods or services or as soon as reasonably possible that the enrollee is qualified to receive comprehensive coverage under the risk pool. Any health care provider or provider of pharmacy goods or services who provides goods or services to an enrollee and requests payment is deemed to have agreed to the reimbursement system as provided for in §§ 58-17- 68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive. Each health care provider shall be reimbursed using medicare reimbursement methodologies at a rate that is designed to achieve a payment that is equivalent to one hundred thirty-five percent of South Dakota's medicaid reimbursement for the goods or services delivered. Each provider of pharmacy goods or services shall be reimbursed at one hundred fifteen percent of South Dakota's medicaid reimbursement for any goods or services provided. Any reimbursement rate to a provider is limited to the lesser of billed charges or the rates as provided by this section. In no event may a provider collect or attempt to collect from an enrollee any money owed to the provider by the risk pool nor may the provider have any

recourse against an enrollee for any covered charges in excess of the copayment, coinsurance, or deductible amounts specified in the coverage. However, the provider may bill the enrollee for noncovered services.

Source: SL 2003 (SS), ch 1, § 11; SL 2006, ch 256, § 1.

58-17-124. Promulgation of rules--Scope of rules. The board may promulgate rules, pursuant to chapter 1-26, necessary for the operation of the risk pool. Any rule promulgated pursuant to this section shall be designed to assure the fair, equitable, and efficient operation of the risk pool. The board shall consult with and consider any recommendations of the advisory panel. The rules may address the following:

(1) Definition of terms;

(2) Provider reimbursement and participation;

(3) Rating;

(4) Assessments;

(5) Eligibility;

(6) Notices, forms, and disclosures;

(7) Plan benefits, exclusions, and requirements;

(8) Reports and audits; and

(9) Cost containment and intervention mechanisms.

Source: SL 2003 (SS), ch 1, § 12.

58-17-125. Premium rates to be reasonable--Establishment of rates--Determination of average carrier rates--Actuarial adjustment of rates. The premium rates for coverages provided by the risk pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing coverage. Case characteristics as allowed pursuant to § 58-17- 74 may be used in establishing rates for those covered by the risk pool. The rates shall take into consideration the extra morbidity and administrative expenses, if any, for enrollees in the risk pool. The rates for a given classification for those that qualify for coverage pursuant to § 58-17-85 shall be one hundred fifty percent of the average in force premium or payment rate for that classification charged by the three carriers with the largest number of individual health benefit plans in the state during the preceding calendar year. In determining the average rate of the three largest individual health carriers, the rates or payments charged by the carriers shall be actuarially adjusted to determine the rate or payment that would have been charged for benefits similar to those provided by the risk pool.

Source: SL 2003 (SS), ch 1, § 13.

58-17-126. Annual fiscal determination of payments, costs and losses--Abatement or deferral of loss assessments--Initial or interim assessments--Maximum assessments--Gains--Assessment of carriers. Following the close of each fiscal year, the board shall determine the net premiums and payments, the expenses of administration, and the incurred losses of the risk pool for the year. In sharing losses among the carriers, the board may abate or defer in any part the assessment of a carrier, if, in the opinion of the board, payment of the assessment would endanger the ability of the carrier to fulfill its contractual obligations. The board may also provide for an initial or interim assessment against carriers if necessary to assure the financial capability of the risk pool to meet the incurred or estimated claims expenses or operating

expenses of the risk pool. This assessment may not exceed twenty-five cents per covered life per month from the time period the risk pool becomes effective. Net gains shall be held at interest to offset future losses or allocated to reduce future assessments.

The assessment of each carrier shall be based upon the number of persons each carrier covers through primary, excess, and stop loss insurance in this state and shall be as follows:

(1) In addition to the powers enumerated in §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, the board may assess carriers in accordance with the provisions of this section, and make advance interim assessments as may be reasonable and necessary for the risk pool's organizational and interim operating expenses;

(2) Following the close of each fiscal year, the board shall determine the expenses of administration, the net premiums (premiums less reasonable administrative expense allowances), and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the risk pool shall be recouped by assessments apportioned under this section by the board among carriers and from other sources as may be allowed under law;

(3) Each carrier's assessment shall be determined by multiplying the total assessment of all carriers as determined in subdivision (2) by a fraction, the numerator of which equals the number of individuals in this state covered under health benefit plans and certificates, including by way of excess or stop loss coverage, by that carrier, and the denominator of which equals the total number of all individuals in this state covered under health insurance policies and certificates, including by way of excess or stop loss coverage, by all carriers, all determined as of the end of the prior calendar year;

(4) The board shall make reasonable efforts designed to ensure that each insured individual is counted only once with respect to any assessment. For that purpose, the board shall require each carrier that obtains excess or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured, including by way of excess or stop loss

coverage, in whole or part. The board shall allow a carrier who is an excess or stop loss carrier to exclude from its number of insured individuals those who have been counted by the primary carrier, the primary reinsurer, or the primary excess or stop loss carrier for the purpose of determining its assessment under this section;

(5) Each carrier shall file with the board annual statements and other reports deemed to be necessary by the board. The board shall determine each carrier's assessment based on these annual statements and reports. The board may use any reasonable method of estimating the number of insureds of a carrier if the specific number is unknown. With respect to carriers that are excess or stop loss carriers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer or excess or stop loss carrier;

(6) Each carrier may petition the board for an abatement or deferment of all or part of an assessment imposed by the board. The board may abate or defer, in whole or in part, the assessment if, in the opinion of the board, payment of the assessment would endanger the ability of the carrier to fulfill its contractual obligations. If an assessment against a carrier

is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other carriers in a manner consistent with the basis for assessments set forth in this section. The carrier receiving such deferment is liable to the risk pool and remains liable for the deficiency.

Any assessment of the carrier is due and payable on any covered person who is a resident in this state regardless of the state of issuance of the policy or master policy.

Source: SL 2003 (SS), ch 1, § 14.

58-17-127. Audits, periodic and annual. The board may conduct periodic audits to assure the general accuracy of the financial data submitted to it and may require the plan administrator

or any contractor to provide the board with an annual audit of its operations to be made by an independent certified public accountant.

Source: SL 2003 (SS), ch 1, § 15.

58-17-128. Plans--Filing and approval. Any plan provided pursuant to §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, shall be filed with and approved by the director before its use.

Source: SL 2003 (SS), ch 1, § 16.

58-17-129. No fee or tax applicable to pool. No fee or tax levied by this state or any of its political subdivisions applies to the risk pool or any function of the risk pool performed in pursuance of §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive.

Source: SL 2003 (SS), ch 1, § 17.

58-17-130. Pool to offer three plan designs--Board to establish coverage and benefits--Alteration by law--Deductibles and expenses--Out-of-pocket maximum--Mental illness coverage-- Additional designs. The risk pool shall offer three plan designs that provide comprehensive coverage benefits consistent with major medical coverage currently being offered in the individual health insurance market and that include a disease management program. The coverage and benefits for plans provided pursuant to §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, may be established by the board, consistent with the

requirements of §§ 58-17-68, 58-17-70, 58-17- 85, and 58-17-113 to 58-17-142, inclusive, and may not be altered by any other state law without specific reference to §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, indicating a legislative intent to add or delete from the coverage provided pursuant to §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive. The three plan designs, henceforth known as Plan A, Plan B, and Plan C, shall have annual deductibles of one thousand dollars, three thousand dollars, and ten thousand dollars, respectively. After the deductible has been met, the plan shall pay seventy-five percent of the eligible expenses and the enrollee is responsible for the balance of the coinsurance amount. The enrollee is responsible for a maximum out-of-pocket coinsurance amount of two thousand two hundred fifty dollars in addition to the deductible amount. All three plans shall cover biologically-based mental illnesses on the same basis as other covered illnesses. The board may create additional plan designs to meet federal requirements for qualifying high deductible health plans for health savings accounts.

Source: SL 2003 (SS), ch 1, § 18; SL 2005, ch 266, § 2.

58-17-131. Disease management programs--Cost containment mechanisms--Enrollee non-participation and expense responsibility. Each plan shall include disease management programs that contain cost containment mechanisms. If the enrollee does not enroll and participate in the applicable cost containment activities, the enrollee is responsible for fifty percent of the eligible expenses for related services after the deductible is met, and there is no maximum out-of-pocket coinsurance amount.

Source: SL 2003 (SS), ch 1, § 19.

58-17-132. Pharmacy benefits--Deductibles and coinsurance amounts--Refusal of intervention or cost containment mechanism. Each plan shall provide pharmacy benefits. In addition to deductibles and coinsurance amounts in § 58-17-130, the enrollee shall pay a twenty-five percent coinsurance for each prescription up to the maximum out-of-pocket coinsurance amount of fifteen hundred dollars. If an intervention or cost containment mechanism is refused without a verifiable medical reason, the enrollee shall pay a fifty percent coinsurance amount and only twenty-five percent of the coinsurance applies toward the maximum out-of- pocket coinsurance amount for pharmacy benefits.

Source: SL 2003 (SS), ch 1, § 20.

58-17-133. Plan-year benefit maximums. Each plan shall offer the following plan-year benefit maximums:

(1) Thirty days coverage for inpatient alcoholism and substance abuse treatment;

(2) Two thousand dollars for outpatient alcoholism and substance abuse treatment; and

(3) Nine hundred dollars for up to thirty outpatient mental health visits for qualified conditions that are not biologically-based.

Source: SL 2003 (SS), ch 1, § 21.

58-17-134. Lifetime benefit maximums. Each plan shall provide the following lifetime benefit maximums:

(1) One million dollars in paid expenses; and

(2) Ninety days coverage for inpatient alcoholism and substance abuse treatment.

Source: SL 2003 (SS), ch 1, § 22.

58-17-135. Newborn coverage and eligibility. Any plan provided pursuant to §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, shall extend newborn coverage pursuant to §§ 58-17-30.2 to 58-17-30.4, inclusive, and shall provide that the newborn is eligible for an individual risk pool plan unless deemed ineligible pursuant to § 58-17-136.

Source: SL 2003 (SS), ch 1, § 23.

58-17-136. Noneligibility of certain persons--Coverage under risk pool provisions in excess of other governmentally-provided insurances--Exception--Ineligibility of enrollee at lifetime maximum--Termination of coverage--Employer-paid premium deemed equivalent coverage. Except as otherwise provided in §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, no person is eligible for a plan created by §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17- 142, inclusive, if the person, on the effective date of coverage, has or will have coverage as an insured or covered dependent under any insurance plan that has creditable coverage as defined in § 58-17-69; is eligible for benefits under chapter 28-6 at the time of application; is an inmate of any public institution or is eligible for public programs for which medical care is provided; or has his or her premiums paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider. Coverage under a plan provided pursuant to §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, is in excess of, and may not duplicate, coverage under any other form of health insurance, employee/employer welfare plan, medical coverage under any homeowner's or motorized vehicle insurance, no-fault automobile coverage, service or payment received under the laws of any national, state, or local government, TRICARE, or CHAMPUS. This section does not apply to those persons meeting the provisions of chapter 28-

13. An enrollee of the risk pool who has met the lifetime maximum under the risk pool plan is ineligible for further benefits as an enrollee in the risk pool.

Coverage provided pursuant to §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, terminates for any person on the date that, if such circumstance had been present at the time of application, the person would have been ineligible for coverage provided by §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive. Coverage may also be terminated for nonpayment of premiums.

For purposes of this section, if any premium is paid to the risk pool by an employer, other than an employer with only one employee, the enrollee is deemed to have equivalent coverage and is ineligible for the risk pool.

Source: SL 2003 (SS), ch 1, § 24.

58-17-137. Rates not to change except on class basis--Disclosure. The rates for any plan created by §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, may not change except on a class basis with a clear disclosure in the plan.

Source: SL 2003 (SS), ch 1, § 25.

58-17-138. Limitations on civil actions or criminal liability--Request for hearing. None of the following may be the basis of any civil action or criminal liability against the board or any individual member of the board, or the risk pool, either jointly or separately: the establishment of rates, forms, or procedures for coverage provided pursuant to §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive; serving as a member or carrying out the functions of the

board; or any joint or collective action required by §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58- 17-142, inclusive. Any person aggrieved by a determination or administrative action made pursuant to §§ 58-17-68, 58-17-70, 58-17-85, and 58-17-113 to 58-17-142, inclusive, may request a contested case hearing pursuant to chapter 1-26, which constitutes the person's sole remedy.

Source: SL 2003 (SS), ch 1, § 26.

58-17-139. Carrier to provide notice of availability and application form--Format. Any carrier authorized to provide individual health care insurance or coverage for health care services in this state shall provide notice of the availability of the coverage provided by §§ 58-17-68, 58-17-70, 58- 17-85, and 58-17-113 to 58-17-142, inclusive, and an application for such coverage to those individuals eligible pursuant to § 58-17-85. The director shall prescribe the format for the notice, and the board shall prescribe the application forms and make them available to the carriers.

Source: SL 2003 (SS), ch 1, § 27.

58-17-140. Recision of policies issued prior to August 1, 2003. Any carrier that issued a basic or standard policy pursuant to § 58-17-85 prior to August 1, 2003, with an original effective date of August 1, 2003, or thereafter, to a person who applied for a basic or standard policy and is eligible for the risk pool may rescind that policy. The carrier shall forward all application materials of any person whose policy was rescinded pursuant to this section to the

risk pool and the person shall be provided with coverage under the risk pool as provided by §§ 58-17-68, 58-17-70, 58-17-85, and 58- 17-113 to 58-17-142, inclusive.

Source: SL 2003 (SS), ch 1, § 31.

58-17-141. Commissions paid to insurance producer not to exceed three percent. No commission paid to any insurance producer for placing coverage with the risk pool may exceed three percent.

Source: SL 2003 (SS), ch 1, § 32.

58-17-142. Maximum premium rates for plans issued prior to August 1, 2003--Rate provisions of § 58-17-75 to apply upon carrier's discontinuance of active marketing . Any carrier of any in force individual health benefit plan issued in accordance with § 58-17-85 prior to August 1, 2003, for which rates are established pursuant to § 58-17-75, may set and charge a maximum premium rate of not more than two and two-tenths times the base premium rate until January 1, 2005, and may set and charge a maximum premium rate of not more than two and one-half times the base premium rate for each year thereafter, if the carrier actively markets individual major medical policies in this state during the entire year of 2003 and each year thereafter. If, in any year after 2003, the carrier discontinues actively marketing individual health benefit plans in this state, the premium rate provisions of § 58-17-75 apply to those policies in force issued pursuant to § 58-17-85 from the date of the carrier's discontinuance of active marketing.

Source: SL 2003 (SS), ch 2, § 1.

58-17-143. Preferred provider contracts with out-of-state providers--Limitations on payments by risk pool. The board may, directly or indirectly, enter into preferred provider contracts to obtain discounts on goods or services from out-of-state providers. If health care goods or services are provided pursuant to a preferred provider contract and the goods or services are either not readily available in this state or are emergency services as defined by § 58-17C-27, the provisions of that contract shall govern the reimbursement rate. The payment by the risk pool for any services received from out-of-network providers in other states, other than emergency treatment as defined in § 58- 17C-27, is limited to one hundred fifteen percent of South Dakota's medicaid reimbursement. Emergency treatment, as defined in § 58-17C-27, that is from an out-of-state provider that is an out- of-network provider, to the extent that such services are payable under the plan, may be reimbursed by the risk pool at an amount that does not exceed the amount determined to be reasonable by the plan administrator.

Source: SL 2005, ch 266, § 1.